STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155042	A. BUILDING _____ B. WING _____	R-C 02/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIDGE HEALTH INVESTORS LLC	3801 OLD BRUCEVILLE ROAD, BOX 136 VINCENNES, IN 47591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN000084156 and Complaint IN00084086 completed on 1/4/11. This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure survey completed on 12/7/10. Complaint IN00084156- corrected Complaint IN00084086-corrected Survey dates: February 2, 3, and 7, 2011 Facility number: 000016 Provider number: 155042 AIM number: 100291500 Survey team: Terri Walters, RN TC Martha Saull, RN Elizabeth Harper, RN Carole McDaniel, RN Census bed type: SNF: 23 SNF/NF: 93 Total: 116 Census payor type: Medicare: 23 Medicaid: 76 Other: 17 Total: 116 Sample: 6 Fox Ridge Health Investors LLC was found to be in compliance with 42 CFR Part 483, Subpart B	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155042	A. BUILDING _____ B. WING _____	R-C 02/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIDGE HEALTH INVESTORS LLC	**3801 OLD BRUCEVILLE ROAD, BOX 136 VINCENNES, IN 47591**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 and 410 IAC in regard to the PSR to Complaint IN00084156 and Complaint IN00084086. Quality review completed on February 9, 2011 by Bev Faulkner, RN	{F 000}		